IMMUNIZATION STATUS ASSESSMENT FORM

A. Ages Under Six (6) Years of Age:

1. Please indicate the dates of the following Immunizations:

	Approximate Date
Measles/Mumps/Rubella (MMR)	_____
Diptheria/Tetanus/Pertusis (DPT)	_____
Haemophilus Influenza-B (Hib)	_____
Hepatitis B	_____
Rotavirus	_____
Inactivated Poliovirus	_____
Pneumococcal	_____
Varicella	_____
Meningococcal	_____

B. Ages Six (6) Years to Less Than 18 Years of Age:

1. Have you ever been informed of any deficiency in immunization by your child's school?

☐ Yes ☐ No

If Yes, List deficiencies: _____

_____

2. Date of last DT or DPT: _____ ☐ Unknown

C. Consent/Refusal

As advised by the Department of Health, do you desire the Urgent Care Clinic to administer the appropriate immunizations? I acknowledge that I understand the benefits and risks of these immunizations and have received discharge instructions.

☐ YES I do desire the clinic to administer the necessary immunizations.

☐ NO I do not want WiseCare Urgent Care to administer the necessary immunizations and my reason for refusal

Signature: _____ Print Name: _____

Date: _____ Relationship to Patient: _____

If, based upon the immunization history of the patient an immunization is indicated but a medical contraindication exists, document the contraindication below: